



Original Article:

Desire for Children and Fear of Side Effects – A Basic Barrier for Acceptance of Contraceptive Services in Rural Area of Central India.

Authors

Choudhari SG, Assistant Professor cum Epidemiologist, Department of Community Medicine, Jawaharlal Nehru Medical College and AVBR Hospital, Sawangi (M), Wardha, State-Maharashtra, India,

Kadu AV, Assistant Professor, Department of Preventive and Social Medicine, Dr.V.Pawar Medical College & Research Centre, Nashik, State-Maharashtra, India,

Raut Y, Statistician cum Lecturer, Department of Community Medicine, Jawaharlal Nehru Medical College and AVBR Hospital, Sawangi (M), Wardha, State-Maharashtra, India.

Address for Correspondence

Choudhari SG,

Assistant Professor cum Epidemiologist,

Department of Community Medicine,

Jawaharlal Nehru Medical College and AVBR Hospital,

Sawangi (M), Wardha,

Maharashtra, India.

E-mail: sonalic27@yahoo.com

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Abstract: Background: According to UN projection India's population will reach 1.53 billion by the year 2050 and will be the highest population in the world. The success of the present RCH-II programme relies on the acceptance of contraceptive methods in reproductive age group. **Objective:** To determine the prevalence, type of contraceptive used and reasons for not accepting contraceptives in rural Maharashtra. **Methodology:** A cross sectional study was carried out in field practice area of a rural tertiary health care hospital in Wardha district of Maharashtra, India. Married women in the reproductive age group of 15 to 49 years were the study participants. **Results:** Out of total 378 women respondents 223(58.99%) were contraceptive acceptors. 62.78% women accepted permanent method of contraception. Among the temporary methods most commonly accepted was Copper-T by 20.62% women. Commonest reason for not accepting contraceptives was desire of children in 30.32% women followed by fear of side effects in 18.06%. **Conclusion:** Many factors like desire for children; especially a male child, fear of side effects of contraceptives, breastfeeding, attended the menopause...etc converge to shape a woman's attitudes about the use of and the need for contraception.

Key Words: Contraceptive acceptance; Women; Reproductive age group.

Introduction:

India is among the most populous ten countries of the world. At present India's population is second to that of China.

According to UN projection India's population will reach 1.53 billion by the year 2050 and will be the highest population in the world.(1) According to census 2011, Indian population stood at 1,21,01,93,422. The last decade has seen India's population growth by 17.64 %.(2)

However NFHS-III(3) reported that fertility continues to decline in India. The current total fertility rate of 2.7 is slightly down than 2.9 children per woman at the time of NFHS-II but is still well above the replacement level of just over two children per woman. In urban areas, the TFR has reached replacement levels (2.1), but in rural areas the TFR is 3.0.

Maharashtra state is the second populous state in India with 96.75 million population i.e. 9.42% contribution, though the TFR of Maharashtra is 1.8 to 2.1 % (replacement or below replacement level).(4)

A woman's reproductive period is roughly from 15 to 45 years- a period of 30 years. In India, these women of the child bearing age (15-44 years) constitute 22.2% of the total population.(5) Gender equality, empowerment of women, elimination of all kinds of violence against women and ensuring women ability to control their own fertility are the corner-stones of population and development related programmes. The success of the present RCH-II programme relies on the acceptance of contraceptive methods in reproductive age group.(6)

It has also been noted that women in developing countries are either under collective decision making with their partners or

completely rely on the male partner's decision on issues that affect their reproductive life. Identifying the major barriers of married women's decision making power on contraceptive use has significant relevance for planning contextually appropriate family planning interventions.(7) Again the extent of acceptance of contraceptive methods still varies within societies and also among different castes and religious groups. The factors responsible for such varied picture operate at the individual, family and community level with their root in the socioeconomic and cultural milieu of Indian society.(8) With this background, the present study was conducted to find out the prevalence of contraceptive acceptance and to determine the type of contraceptive used and barriers or reasons for not accepting contraceptives in rural Maharashtra.

Material and Methods:

The present community based cross sectional study was carried in the rural field practice area, Seloo of a rural tertiary health care hospital in Wardha district of Maharashtra state during January to March 2013. Married women in the reproductive age group of 15 to 49 years were included in the study as study participants. Widowed, divorced or separated and pregnant women were excluded from the study. Sample size was calculated by using following formula: Sample size = $n = Z^2 [P (1-P)] \div d^2$, where P = 66.9% (Prevalence of contraceptive use among married women of reproductive age group 15-49 years for Maharashtra state as reported by NFHS-III), Confidence: 95%, so Z=1.96 and absolute precision: d = 5%. Sample size is = $(1.96)^2 (0.66) (0.34) / (0.05)^2 = 344$ and considering 10% non response rate it is almost 378.

Initially house listing of the study area was done and from first 3 houses one was randomly selected by currency note, and then by systematic random sampling every 3rd house was selected. From one household only one woman in 15-49 yrs age group was selected for assessing the contraceptive practices. Confidentiality of response was maintained by coding the participants. If no woman in 15-49 yrs was found in household or not willing to give consent then next 3rd house was selected till the completion of sample size.

Participants were explained about the objectives of the study and an informal verbal consent was obtained from them. Pretested structured questionnaire was administered in local language by face to face interview including their demographic profile and open ended questions on contraceptive practices. For this study total family income per annum in rupees (in thousands) was recorded and classified as Low Income group (less than Rs. 150,000/-), Middle Income group (Rs. 151,000- 500,000/-), and High income group (more than Rs. 500,000/-) for the Wardha district. Ethical clearance was obtained from Institutional Ethical Committee.

Data was analyzed by number and percentage. Univariate analysis was done by chi square test.

Results:

Sociodemographic profile of women respondents

Out of total 378 married women of reproductive age group, majority 136(35.97%) were having age group 21-30 years followed by 115(30.42%), 112(29.62%) and 15(3.96%) in the age group of 31-40 years, >40 years and <20 years respectively. Mean age of women respondents was 29.05 years. 17(4.49%) women were illiterate while rest were literate. Homemakers 205 (54.23%) outnumbered the working women 173(45.77%). Among the working women majority were the agricultural laborers either working in own farm or working in others farm on daily wage basis. 224 (59.25%) were belonging to lower socioeconomic status. Contraceptive acceptance

Out of total 378 women respondents 223(58.99%) of them were contraceptive acceptors and 155(41.01%) were non acceptors.

Out of 223 acceptors, majority i.e. 140(62.78) had accepted the contraceptives for limiting their family size i. e. permanent method of contraception while rest 83(37.22%) married women were using the temporary methods of contraception in order to either delay the first pregnancy or to have spacing between the two births. Among the temporary method, IUD was the most commonly accepted i.e., 46(20.62%). Among the permanent method, Tubectomy was accepted by 122(54.7%) married women and among only 18(8.07%) couples the male partner had chosen to undergo vasectomy.

Sociodemographic factors as determinants of contraceptive acceptance are shown in Table 1.

Table 1: Distribution of study participants as per the various sociodemographic variables and contraceptive use				
No	Variable	Contraceptive use		Total (N=378)
		Present (n=223)	Absent (n=155)	
1.	Age(Years)			
	≤20	9(60.00)	6(40.00)	15(100)
	21-30	61(44.85)	75(55.15)	136(100)
	31-40	52(45.22)	63(54.78)	115(100)
	>40	59(52.68)	53(47.32)	112(100)
	$\chi^2 = 2.74, df=3, P= 0.5$			
2.	Literacy status			
	Illiterate	7 (41.18)	10 (58.82)	17(100)
	Primary	71(51.45)	67 (48.55)	138 (100)
	Secondary	111(65.68)	58(34.32)	169(100)
	Higher secondary	21(63.64)	12(36.36)	33(100)
	Graduate	09 (60.00)	06(40.00)	15(100)
	Postgraduate	04(66.67)	02(33.33)	06(100)
	$\chi^2 = 27.75, df=3, p<0.01$ Rows 4,5 and 6 are pooled together			
3.	Religion			
	Hindu	133(51.15)	127(48.84)	260(68.78)
	Muslim	14(31.11)	31(68.89)	45(11.90)
	Buddhist	30(41.10)	43(58.90)	73(19.31)
	$\chi^2 = 7.38, df=2, P=0.02$			
4.	Type of family			
	Nuclear	68(58.11)	49(41.88)	117(100)
	Joint	155 (59.38)	106 (40.61)	261(100)
	$\chi^2 = 0.014, df=1, P=0.9$			
5.	Socioeconomic status			
	Low	128(57.14)	96(42.85)	224(100)
	Middle	55(60.44)	36(39.56)	91(100)
	High	40(63.49)	23(36.51)	63(100)
	$\chi^2 = 0.92, df=2, P=0.6$			

*Figures in parentheses indicate the horizontal percentages

Maximum contraceptive acceptance (i.e. 35.97%) was observed in 21-30 followed by 30.42% in 31-40 years. Among 361 literate women contraceptive acceptors were more 216(59.83%) as compared to non acceptors. The situation was vice versa in illiterates. Again the prevalence of acceptors rises with level of literacy status. Significant difference was observed between literacy status and prevalence of contraceptive acceptors ($\chi^2 = 27.75, df= 3, P<0.01$).

Religion wise distribution of contraceptive acceptors and non acceptors also showed a significant association ($\chi^2 = 7.38$, $df=2$, $P=0.02$). Maximum contraceptive acceptance was seen in women from nuclear family i.e. 68(58.11%) out of 117 in comparison to joint family as well as those who belonged to high socioeconomic status (63.49%). But no significant association found for the same.

Reasons for not accepting contraceptives are shown in Table 2.

Reasons	No (n=155)	%
Desire of children, Want a male child	47	30.32
Fear of side effects	28	18.06
Menopausal	19	12.25
Breast feeding	11	7.09
Infrequent sex, ambivalence about avoiding the pregnancy	15	9.67
Inconvenient for use, difficult to use it consistently	19	12.25
Ignorance about use	17	10.96
Anti religion /Opposition from family	10	6.45
Unmet need	8	5.16
Unsatisfied with the previous method	7	4.51
Other- Hysterectomy, interference with sex, using rhythm method, ...etc	17	10.96
*Multiple responses		

When enquired to non acceptors about the reason for not using any contraceptive, the commonest reason came out to be 'Desire for children by 47(30.32%) women followed by 'Fear of side effects 28(18.06%), having attended menopause, inconvenient for use or difficult to use it consistently each 19(12.25%)...etc. Out of 47 women desiring for more children, 29(61.7%) women were not using any contraceptive because they want a male child; overall the percentage of 'Son preference' as a reason for not using any contraceptive was 18.7% of non acceptors. On the other hand 8(5.16%) women found to have unmet need of family planning.

Discussion:

The contraceptive prevalence among married women of reproductive age group in the present study was found to be 58.99%, which is lower than that of findings for Maharashtra 66.9% (NFHS III, 2005-06)(3) and 62.9% (DLHS-3, 2007-08).(9) The rationale behind using the contraception was to limit the family size rather than to space the births in majority of the families (62.78%). In the present study the most commonly accepted method for contraception was the permanent method i.e. Tubectomy (54.7%) which is almost equal with the findings of DLHS-3 (2007-08) i.e. 54.6%. There is predominance of female sterilization in rural areas, as men do not come forward for vasectomy. Only 18(8.07%) couples had undergone vasectomy in the present study. According to DLHS- 3 (2007-08)(9), 3.2% male had done vasectomy. This reflects the prevailing gender bias in reproductive health participation by men. In India current contraceptive rate of currently married women is 56%. Female sterilization, with prevalence of 37%, accounted for 71% of all contraceptive use in India.(10)

Among the temporary methods, Copper-T (20.62%) was the commonest method accepted followed by oral pills (9.86%) and condom (6.72%). Different studies have shown different preferences for methods of contraception used e.g., in a study(11) in rural community of West Bengal Copper-T was

accepted by 6.4% and condom by 3.5% of couples. In contrast, in a study(8) in rural population of Dehradun districts condoms were used by 11.68% and IUDs by 1.71% couples.

Literacy status of the women of reproductive age group and the religion he belonged to were found to be the variables having significant association with the contraceptive acceptance ($P<0.05$). Similar high prevalence of contraceptive acceptance among literate women was observed by other authors(8). In a study by Verma GR *et al*(12) too literates exhibited an encouraging attitude towards family planning than illiterates. NFHS-III(3) also revealed an inverse association between fertility and educational status. TFR is 1.7 children higher for illiterate women than for women with atleast a high school education. Similarly Muslims have a higher fertility (3.09) than Hindus (2.65).

Less contraceptive acceptance among women with joint family may be due to the fact that the wife in a joint family obtains a higher position in her husband's family only after the birth of child. So in a joint family the women feels encouraged to produce more children. Secondly, some couples in joint family may not have power to take decision. The reasons for non acceptance of contraceptive in majority of women were desire of more children by 30.32% and fear of side effects by 18.06%. 18.7% women expressed 'Wish to have male child' as the reason for not using any contraceptive. As per NFHS-III(3), in states with replacement and below replacement level fertility, son preference is low, but exceptions are Punjab, and Maharashtra. Son preference, though reducing, still persists.

A study(13) in rural area of Uttar Pradesh also cited that 40% respondents wanted more children and 20% had fear of side effects. In another study by Biswas *et al*(11) reasons for non acceptance of contraceptive were desire for more children by 35.5% and fear of side effects by 22.6% of women.

9.67% women were ambivalent about avoiding the pregnancy. Such women are less likely to use contraception and more likely to have gaps in contraceptive use that put them at risk for unintended pregnancy.(14)

In the present study nearly 5% women found to have unmet need of family planning. According to NFHS -III(3), about 12.8% of currently married women in India have an unmet need of family planning both for spacing and limiting the births. It is higher in rural area (14.1%) than urban areas (9.7%). Attitude surveys have shown that awareness of family planning is very widespread and over 60% people have attitudes favorable to restricting or spacing births. People are generally in favour of family planning, and there is no organized opposition to it. In spite of this, the rate of contraceptive use by couples in the developing countries is very low. This is the crux of the family planning programme.

Conclusion and recommendation:

Thus it seems that many factors like desire for children; especially a male child, fear of side effects of contraceptives,...etc converge to shape a woman's attitudes about the use of and the need for contraception. Health care providers should discuss pregnancy risks and contraceptive options with women who are not motivated to prevent pregnancy and emphasize the value of planning for a healthy pregnancy before it occurs. Special strategies are to be planned to improve the involvement of men in fertility regulation and thereby in reproductive health.

Conflicts of Interest: None.

Source of Support: Nil

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